U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 07 June 2005

In the Matter of:

JAMES MCCOY, JR.,
Claimant

Case No.: 2004 BLA 5277

v.

HOLLY BETH COAL, INC./
ROCKWOOD INSURANCE COMPANY
Employer/Insurer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

Appearances:
Mr. Ron Carson, Representative
For the Claimant

Ms. Anne L. Musgrove, Attorney
For the Employer

Before:
Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER – AWARD OF BENEFITS

This matter involves a claim filed by Mr. James McCoy, Jr. for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

Procedural Background

Initial Claim
(DX 1)[1]

Initial Adjudication

Mr. McCoy filed his first application for black lung disability benefits on February 9, 1987. On September 18, 1987, the Deputy Commissioner at the Department of Labor ("DOL") initially determined that Mr. McCoy was entitled to benefits and named Holly Beth Coal, Inc. ("Holly Beth") the responsible operator. Due to the Employer's appeal, interim benefit payments were initiated by the Black Lung Disability Trust Fund and the case was referred to the Office of Administrative Law Judges ("OALJ"). In July 1988, Administrative Law Judge John Patton remanded the case to the Director for determination of the responsible operator issue. Then, on March 15, 1989, the Deputy Commissioner made another determination that Mr. McCoy was entitled to benefits, naming Black Widow Coal Co. ("Black Widow") as the responsible operator. The case was again referred to the OALJ in May 1989, naming both Holly Beth and Black Widow as putative responsible operators.

Administrative Law Judge Giles J. McCarthy conducted a hearing on April 17, 1990 and subsequently denied Mr. McCoy's claim for benefits. Although Mr. McCoy had established that he had coal workers' pneumoconiosis, he did not prove total disability. Judge McCarthy also determined that Mr. McCoy established 28 ¾ years of coal mine employment. Mr. McCoy appealed the decision. On February 19, 1993, the Benefits Review Board ("BRB" or "Board") affirmed Judge McCarthy's decision.

First Modification Request

On January 27, 1994, Mr. McCoy requested a modification of the denial of his claim. The District Director denied his request in a proposed decision and order issued March 17, 1994. Mr. McCoy appealed the adverse decision. After a Memorandum of Conference, the District Director recommended denial of Mr. McCoy's claim. The case was referred to OALJ where Administrative Law Judge Charles P. Rippey denied Mr. McCoy's request for modification in a decision dated November 22, 1995.

Second Modification Request

Mr. McCoy again requested modification of the denial of his claim on October 11, 1996. The District Director issued a proposed decision and order denying the request on December 10, 1996.

[1]The following notations appear in this decision to identify exhibits: DX – Director exhibit; CX – Claimant exhibit; EX – Employer exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

Third Modification Request

Mr. McCoy requested modification again on March 31, 1997. The District Director denied Mr. McCoy's modification request on July 9, 1997 and Mr. McCoy appealed the decision. The case was referred to the OALJ and Administrative Law Judge Richard Morgan conducted a hearing on March 20, 1998. Judge Morgan issued a decision on July 27, 1998 naming Holly Beth the responsible operator and finding that Mr. McCoy established the presence of pneumoconiosis; however, he was not totally disabled. Mr. McCoy appealed the adverse decision to the BRB.

On May 17, 2000, the BRB issued a decision and order vacating and remanding Judge Morgan's decision. The Board affirmed all issues except for Judge Morgan's consideration of whether the x-ray evidence established the presence of complicated pneumoconiosis instructing him to review all of the chest x-ray evidence of record, not just the newly submitted evidence. On remand, Judge Morgan invited the parties to submit briefs and subsequently issued a decision on September 26, 2000, denying benefits to Mr. McCoy. Judge Morgan found that complicated pneumoconiosis was not present because the evidence established that the opacities found upon x-ray did not represent complicated pneumoconiosis.

Fourth Modification Request

On December 21, 2000, Mr. McCoy again requested modification of the denial of his claim and submitted medical treatment records through June 2000. The District Director issued a proposed decision and order on March 28, 2001 denying the modification request, finding that Mr. McCoy failed to establish total disability. Mr. McCoy did not appeal the adverse decision.

Second, and Present Claim

On April 22, 2002, Mr. McCoy filed his second and present claim (DX 3). On October 3, 2002, the District Director issued a notice indicating that Mr. McCoy would be entitled to benefits if a decision was issued at that time; however, the parties were provided an opportunity to file additional evidence (DX 29). After a review of additional evidence, the District Director denied Mr. McCoy's claim on August 28, 2003, finding simple pneumoconiosis but not that Mr. McCoy was totally disabled (DX 41). Mr. McCoy appealed the decision on September 29, 2003 (DX 43), and the case was forwarded to OALJ on December 10, 2003 (DX 46). Pursuant to a Notice of Hearing, dated March 17, 2004 (ALJ I), I conducted a hearing in Abingdon, Virginia on June 9, 2004 attended by Mr. McCoy, Mr. Carson and Ms. Musgrove.

Evidentiary Discussion

Post-hearing Evidence – CX 5 and EX 10

At the hearing, I kept the record open for 30 days for the submission of additional evidence. Specifically, I gave the Employer an opportunity to submit rebuttal evidence of the biopsy and CT scan taken in June 2002. Likewise, the Claimant was permitted to submit rebuttal evidence to the May 2004 chest x-ray. On July 29, 2004, I received from Employer's counsel a

report from Dr. Hippensteel, dated July 1, 2004, in which he considered the additional medical evidence, marked as EX 9. I also received from Claimant's personal representative on June 21, 2004 an interpretation by Dr. Alexander of the May 2004 chest x-ray, marked as CX 5. Therefore, I admit the supplemental report from Dr. Hippensteel as EX 10 (EX 9 was already in evidence) and the May 2004 chest x-ray interpretation by Dr. Alexander as CX 5.

Deferred Decision - EX 6

Additionally, based on the Claimant's objection, I deferred a decision on the admission of EX 6, Dr. Renn's chest x-ray interpretation,[2] because it represented a second rebuttal interpretation of the October 22, 2003 chest x-ray film. Counsel for Employer argues that the Employer is entitled to submit two interpretations of this x-ray as rebuttal evidence because Claimant offered two interpretations of the October 2003 x-ray as its two case-in-chief x-ray interpretations.

According to 20 C.F.R. § 725.414 (a) (3) (ii), "the responsible operator shall be entitled to submit, in rebuttal of the case presented by the claimant, no more than one physician's interpretation of each chest x-ray, pulmonary function test, . . . submitted by the claimant."[3] The Employer believes the phrase "each chest x-ray" should be read as "each chest x-ray interpretation." Upon initial consideration, language of the regulation seems fairly clear, because although the word "interpretation" is used to identify the employer's rebuttal submission, the word does not also follow the term "chest x-ray" in the same regulatory sentence. Absent inclusion of that additional word, the term "chest x-ray" appears to means the radiographic film or study and not the interpretation of that radiographic image. However, upon further consideration of the actual hearing process, the Employer's argued interpretation is equally reasonable. When a claimant submits evidence in support of his claim, he does not submit a chest x-ray film or study. Instead, he submits an interpretation of a chest x-ray. In that light, the regulatory provision regarding rebuttal to a claimant's submission of a "chest x-ray" must be referencing the interpretation of the film, rather than the actual chest x-ray itself. Additionally, besides the absence of the word "interpretation" after term "chest x-ray," the regulatory provision likewise does not include the words "film" or "study" after "chest x-ray" either.

In light of this ambiguity and in the absence of any interpretation by the Benefits Review Board or appellate courts on this regulatory evidentiary limitation I turn to one final consideration that leads me to conclude EX 6 should be admitted. If the regulatory term is interpreted to mean chest x-ray film or study, then each side has the opportunity to present at least one chest x-ray film that is not rebuttable by the other party. For example, assuming the radiologists interpreting a chest x-ray have the same qualifications and no other discriminating factors are present, a claimant could submit two interpretations of one radiographic image, as in Mr. McCoy's case, that would outnumber and outweigh the employer's one rebuttal interpretation. Absent statutory language in the Act authorizing such irrebuttable evidence, I

[2]Dr. Renn found the presence of simple pneumoconiosis, profusion 1/1, type p/q opacities in the October 22, 2003 chest x-ray, but he did not observe any large pneumoconiosis opacities.

[3]The regulation at 20 C.F.R. § 725.414 (a) (2) (ii) also utilizes the same language in regards to a claimant's rebuttal chest x-ray interpretations.

find the interpretation that produces such a result inconsistent with the full and fair hearing process accorded to the parties under the Administrative Procedures Act. Accordingly, I believe the ambiguous term "chest x-ray" in 20 C.F.R. § 725.414 (a) (3) (ii) means chest x-ray interpretation rather than chest x-ray film. Accordingly, I admit EX 6 into evidence.[4]

Additional Chest X-Ray Interpretation – EX 7

During his May 2004 deposition, Dr. Hippensteel provided his interpretation of the September 2002 chest x-ray that was obtained as part of his pulmonary evaluation of Mr. McCoy. As part of its case-in-chief, the Employer submitted an interpretation of the same chest x-ray by Dr. Wheeler rather than Dr. Hippensteel. Consequently, considering the other submissions by the Employer, Dr. Hippensteel's interpretation exceeds the evidentiary limitation established by 20 C.F.R § 725.414 (a) (3) (i)[5] and I will not consider his opinion on this film in analyzing the radiographic evidence.

Due to the inadmissibility of Dr. Hippensteel's chest x-ray interpretation, another issue arises concerning his medical report. Under 20 C.F.R. § 725.414 (a) (3) (i), each chest x-ray interpretation that appears in a medical report must be otherwise admissible. Thus, ironically, in reaching his medical conclusion about Mr. McCoy's pulmonary condition, Dr. Hippensteel procedurally is not allowed to include or reference his own chest x-ray interpretation. I have considered whether this evidentiary deficiency invalidates Dr. Hippensteel's entire medical report. However, I conclude his x-ray reference does not render the report inadmissible. Dr. Hippensteel mostly agreed with Dr. Wheeler's interpretation of the film. Thus, even excluding this own chest x-ray interpretation, Dr. Hippensteel's assessment is nevertheless supported by an admissible, and similar, chest x-ray interpretation of the same film. Accordingly, I have not excluded Dr. Hippensteel's medical evaluation and deposition from the record.

Additional Chest X-Ray Interpretation – EX 8

In same manner as Dr. Hippensteel, during his June 2004 deposition, Dr. McSharry noted his interpretation of the May 2004 chest x-ray that was part of his examination of Mr. McCoy. Since Dr. McSharry's interpretation also exceeds the evidentiary limitations for the Employer, I will not consider his opinion on this film in analyzing the radiographic evidence.

On the admissibility of Dr. McSharry's medical report and deposition, I again conclude that his x-ray interpretation does not render the report inadmissible because his understanding of the May 2004 chest x-ray was consistent with the admissible interpretation by Dr. Scartiage.

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[4]Employer also sought the admission of EX 6 into evidence on the basis of good cause. Title 20 C.F.R. § 725.456 (b)(1) permits the admission of evidence in excess of the evidentiary limitations set forth at 20 C.F.R. §725.414 upon a showing of good cause. However, counsel for Employer has failed to show why this particular case particular requires the submission of additional evidence for good cause.

[5]According to 20 C.F.R. § 725.414 (a) (3) (i), an employer may submit no more than two chest x-ray interpretations in support of its affirmative case.

Summary

In light of the above comments, my decision in this case is based on the hearing testimony and the following exhibits admitted into evidence: DX 1 to DX 47, CX 1 to CX 5, EX 1 to EX 10.

ISSUES

1. Whether, in filing a subsequent claim on April 22, 2002, Mr. McCoy has demonstrated that a change has occurred in one of the conditions, or elements, of entitlement, upon which the final denial of his prior claim was based in March 2001.

2. If Mr. McCoy establishes a change in one of the applicable conditions of entitlement, whether he is entitled to benefits under the Act.

3. If Mr. McCoy is entitled to benefits under the Act, whether the onset of his total disability predated his employment with the Employer, Holly Beth Coal, Inc., precluding its liability as the responsible operator.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Preliminary Findings

Mr. McCoy, a widower, was born on July 11, 1931. He started working in the coal mines in August 1956 and worked until October 1986. Because of some brief periods where Mr. McCoy was off of work, his total length of coal mine employment is 28 ¾ years. Mr. McCoy left coal mining because of back problems and upon advice from his physician, Dr. Sutherland, that his health was worsening due to his breathing coal dust. In his last position as a coal miner, Mr. McCoy was a roof bolt helper, which required him to set steel jacks for the bolter. As part of his work, Mr. McCoy had to lift the jacks weighing up to fifteen pounds. Mr. McCoy was not able to stand because he worked in 28 to 32 inch high seams of coal and therefore his job required a lot of bending and crawling. He also pulled a wagon containing supplies that weighed at least 50 pounds (TR, pages 25 to 31 and 36).

Mr. McCoy began experiencing breathing problems in 1972 or 1973 that presented as shortness of breath with exertion. Presently, he has difficulty climbing a set of stairs. Dr. Robinette treats Mr. McCoy with breathing pills to improve his condition. Mr. McCoy started smoking in 1950 or 1951 and stopped in 1968, smoking 9 cigars and 3 to 4 pipes of tobacco per day. Mr. McCoy started dipping tobacco in 1956 or 1957 and continues to dip with a box lasting him two days. Mr. McCoy has not been gainfully employed since working in the coal mines in 1986 (TR, pages 31, and 34 to 40).

Issue # 1 – Change in Applicable Condition of Entitlement

Any time within one year of a denial or award of benefits, any party to the proceeding may request a reconsideration based on a change in condition or a mistake of fact made during the determination of the claim. 20 C.F.R. § 725.309 (c) and 20 C.F.R. § 725.310. However, after the expiration of one year, the submission of additional material or another claim is considered a subsequent claim which will be considered under the provisions of 20 C.F.R. § 725.309 (d). That subsequent claim will be denied unless the claimant can demonstrate that at least one of the conditions of entitlement upon which the prior claim was denied ("applicable condition of entitlement") has changed and is now present. If a claimant does demonstrate a change in one of the applicable conditions of entitlement, then generally findings made in the prior claim(s) are not binding on the parties. 20 C.F.R. § 725.309 (d) (4). Consequently, the relevant inquiry in a subsequent claim is whether evidence developed since the prior adjudication would now support a finding of a previously denied condition of entitlement.

The court in *Peabody Coal Company v. Spese*, 117 F.3d 1001, 1008 (7th Cir. 1997) put the concept in clearer terms:

> The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

In adjudicating a subsequent claim by a living miner in which the applicable conditions of entitlement relate to the miner's physical condition, I focus on the four basic conditions, or elements, a claimant must prove by preponderance of the evidence to receive black lung disability benefits under the Act. First, the miner must establish the presence of pneumoconiosis.[6] Second, if a determination has been made that a miner has pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment.[7] Third, the miner has to demonstrate he is totally disabled.[8] And fourth, the miner must prove the total disability is due to pneumoconiosis.[9]

With those four principle conditions of entitlement in mind, the next adjudication step requires the identification of the conditions of entitlement a claimant failed to prove in the prior claim. In that regard, of the four principle conditions of entitlement, the two elements that are usually capable of change are whether a miner has pneumoconiosis or whether he is totally disabled. *Lovilia Coal Co. v. Harvey*, 109 F.3d 445 (8th Cir. 1997). That is, the second element

[6] 20 C.F.R. § 718.202.

[7] 20 C.F.R. § 718.203 (a).

[8] 20 C.F.R. § 718.204 (b).

[9] 20 C.F.R. § 718.204 (a).

of entitlement (pneumoconiosis arising out of coal mine employment) and the fourth element (total disability due to pneumoconiosis) require preliminary findings of the first element (presence of pneumoconiosis) and the third element (total disability).

In Mr. McCoy's case, his most recent, prior claim was denied in March 2001 for failure to prove total disability. That denial was based on medical evidence developed through June 2000. Consequently, for purposes of adjudicating the present subsequent claim, I will evaluate the new medical evidence developed since June 2000 to determine whether Mr. McCoy can now prove a total respiratory disability.

Total Disability

To receive black lung disability benefits under the Act, a claimant must have a total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204 (b) and 718.304. If that presumption does not apply, then according to the provisions of 20 C.F.R. §§ 718.204 (b) (1) and (2), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills.

While evaluating evidence regarding total disability, an administrative law judge must be cognizant of the fact that the total disability must be respiratory or pulmonary in nature. In *Beatty v. Danri Corp. & Triangle Enterprises and Dir., OWCP*, 49 F.3d 993 (3d Cir. 1995), the court stated, in order to establish total disability due to pneumoconiosis, a miner must first prove that he suffers from a respiratory impairment that is totally disabling separate and apart from other non-respiratory conditions.

Mr. McCoy has not presented evidence of cor pulmonale with right-sided congestive heart failure. As a result, Mr. McCoy must demonstrate total respiratory or pulmonary disability through the presence of complicated pneumoconiosis, pulmonary function tests, arterial blood-gas tests, or medical opinion.

Complicated Pneumoconiosis

The regulation, in part, at 20 C.F.R. § 718.304, provides that if a claimant is able to establish the presence of complicated pneumoconiosis, then an irrebuttable presumption of total disability due to pneumoconiosis is established. In the Black Lung Benefits Act, 30 U.S.C. 921 (c) (3) (A) and (C), as implemented by 20 C.F.R. § 718.304 (a), Congress determined that if a miner is suffering from a chronic dust disease of the lung "which when diagnosed by chest roentgenogram, yields one or more large opacities (greater than one centimeter in diameter) and would be classified in category A, B, or C…there shall be an irrebuttable presumption that he is

totally disabled by pneumoconiosis…"[10] This type of large opacity is called "complicated pneumoconiosis." 20 C.F.R. §§ 718.304 (b) and (c) also permits complicated pneumoconiosis to be established by either the presence of massive fibrosis in biopsy and autopsy evidence or other means which would be expected to produce equivalent results in chest x-rays or biopsy/autopsy evidence.

According to the U.S. Court of Appeals for the Fourth Circuit[11] in *Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250 (4th Cir. 2000), the existence of complicated pneumoconiosis is established by "congressionally defined criteria." As a result, the statute's definition of complicated pneumoconiosis as radiographic evidence of one or more large opacities categorized as size A, B, or C, 30 U.S.C. 921 (c) (3) (A), represents the most objective measure of the condition. This sets the benchmark by which other methods for proving complicated pneumoconiosis are measured, as described in 30 U.S.C. 921 (c) (3) (B) and (C). *Id*. at 256. In other words, whether a massive lesion or other diagnostic results represent complicated pneumoconiosis under 30 U.S.C. 921 (c) (3) (B) and (C) requires an equivalency evaluation with the x-ray criteria set forth in 30 U.S.C. 921 (c) (3) (A).[12] Additionally, the court emphasized that the legal definition of complicated pneumoconiosis as established by Congress controls over the medical community's definition of the disease. *Id*. at 257. Finally, the court indicated that although all relevant and conflicting medical evidence must be considered and evaluated:

> if the x-ray evidence vividly displays opacities exceeding one centimeter, its probative force is not reduced because the evidence under some other prong is inconclusive or less vivid. Instead, the x-ray evidence can lose force only if other evidence affirmatively shows that the opacities are not there or are not what they seem to be, perhaps because of an intervening pathology, some technical problem with equipment, or incompetence. *Id* (emphasis added).

In light of these statutory, regulatory and judicial principles, the adjudication of whether a claimant is able to invoke the irrebuttable presumption under 20 C.F.R. § 718.304 involves a two-step process. First, I must determine whether: a) the preponderance of the chest x-rays establishes the presence of large opacities which would be characterized by size as Category A, B, or C under recognized standards; or b) biopsy evidence or other diagnostic results exist which are equivalent to chest x-ray evidence of large opacities characterized as Category A, B, or C. At this stage of the process, the essential inquiry is whether such large opacities, or their equivalent,

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[10]The definition section of the standard ILO chest x-ray classification worksheet, Form CM 933l, states concerning large opacities that "the categories are defined in terms of dimensions of the opacities." The form then lists three categories, identified by letters. The interpretation finding of Category A indicates the presence of a large opacity having a diameter greater than 10 mm (one centimeter) but not more than 50 mm; or several large opacities, each greater than 10 mm but the diameter of the aggregate does not exceed 50 mm. Category B means an opacity, or opacities "larger or more numerous than Category A" whose combined area does not exceed the equivalent of the right upper zone of the lung. Category C represents one or more large opacities whose combined area exceeds the equivalent of the right upper zone.

[11]Mr. McCoy's case arises within the jurisdiction of this court.

[12]See also 20 C.F.R. §§ 718.304 (b) and (c).

exist. Thus, as observed by the *Scarbro* court, definitive evidence indicating the large opacities are not really present would preclude invocation of the 20 C.F.R. § 718.304 presumption.

Second, if the preponderance of the evidence does demonstrate the existence of large opacities, I must then consider all other relevant evidence to determine whether that evidence affirmatively shows the large opacities are not what they seem to be (complicated pneumoconiosis) due to some other intervening pathology.

Existence of Large Opacities

Mr. McCoy may rely on chest x-ray imaging, biopsy, or other medical tests, such as CT scans, showing the equivalent of a radiographic image, to establish the presence of large opacities. The radiographic evidence in the record is set out below.

Date of x-ray	**Exhibit**	**Physician**	**Interpretation**
December 11, 2001	DX 38	Dr. Mullens, BCR[13]	Chronic interstitial lung disease with multiple ill defined bilateral pulmonary nodules
June 28, 2002	DX 15	Dr. Forehand, B	Positive for complicated pneumoconiosis, profusion 1/2,[14] type p opacities,[15] category B large opacities, multiple pulmonary nodules, 1 to 2 centimeters in diameter, left upper lobe and all three zones right side. 1998 biopsy negative for malignancy.
(same)	DX 17	Dr. Goldstein, B	Multiple large nodules; rule out cancer.

[13]As I informed the parties at the hearing (TR, pages 7 and 8), I take judicial notice of Dr. Mullens' board certification and have attached the certification documentation.

The following designations apply: B – B reader, and BCR – Board Certified Radiologist. These designations indicate qualifications a person may posses to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs. *See also* 20 C.F.R. § 718.202 (a) (1) (ii).

[14]The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1 / 2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Or, a reading of 0/0 means the doctor found no, or few, opacities and didn't see any marks that would cause him or her to seriously consider category 1.

[15]There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

(same)	DX 37 & DX 39	Dr. Hippensteel, B	Positive for pneumoconiosis, profusion 1/0 type p/s opacities, questionable large opacities; partly calcified 1.5 centimeter nodule, left upper lobe. Scattered nodules 0.5 to 2.5 centimeters present in left lower lobe, but more in right lower lobe. Pattern does not look like simple or complicated pneumoconiosis, more compatible with nodular sarcoidosis, considering elevated "ACE".
September 12, 2002	DX 37	Dr. Wheeler, BCR, B	Negative for pneumoconiosis, scattered 5 millimeters to 2 centimeters masses in right lung, compatible with granulamatous disease or metastases; subtle linear interstitial infiltrate or fibrosis compatible with inflammatory disease or possible lymphatic spread.
(same)	CX 3	Dr. Alexander, BCR, B	Positive for pneumoconiosis, profusion 2/3, type p/s opacities, category B large opacities right lower zone and both upper zones; summed diameter of large opacities 55 to 60 millimeters, consistent with category B complicated pneumoconiosis; however metastatic cancer would have similar appearance.
October 22, 2003	CX 1	Dr. Pathak, B	Positive for pneumoconiosis, profusion 2/2, type q/t opacities, category B large opacities, emphysema; several larger nodular densities measuring between 1 and 2 centimeters in size in all six zones.
(same)	CX 2	Dr. Robinette, B	Positive for pneumoconiosis, profusion 2/2, type p/q opacities, category A large opacities, nodular density consistent with coal workers' pneumoconiosis; however needs comparison to old x-rays
(same)	EX 2	Dr. Scatarige, BCR, B	Negative for pneumoconiosis, unchanged (since 1997) 1.5 centimeter nodule in the left upper lobe; interval appearance of interstitial infiltrates involving all lobes and multiple bilateral nodules 5 millimeters to 2 centimeters; emphysema; consistent with metastatic disease, fungal disease, and lymphoma; pneumoconiosis unlikely since no interstitial present in prior chest x-ray study.
(same)	EX 6	Dr. Renn, B	Positive for pneumoconiosis, profusion 1/1, type q/q opacities; no large opacities; mass densities in right lower and left upper lobes consistent with metastatic disease and not progressive massive fibrosis; small nodular densities consistent with metastatic disease. Left lower lobe nodule has marginally increased since 1997.
May 12, 2004	CX 5	Dr. Alexander, BCR, B	Positive for pneumoconiosis, profusion 2/2, type p/q opacities, category B large opacities, 15 millimeter diameter large opacities in upper zones, 25 millimeter large opacity in right lower zone with adjacent emphysematous change.

(same)	EX 1	Dr. Scatarige, BCR, B	Negative for pneumoconiosis, unchanged and benign 1.5 centimeter mass left lower lobe, scattered nodules in right upper lung and right lower lung of questionable etiology; emphysema present. Interval appearance of interstitial infiltrate all lobes and multiple bilateral nodules 5 mm to 2 cm, possible chronic pneumonia, infiltrative disease, neoplasm, Wegner's disease or rare amyloidiosis. Central infiltrates have resolved since 2003.
June 2, 2004 (2 x-rays)	CX 4	Dr. Mullens	Multiple ill defined masses and reticulonodular interstitial disease.
(same)	EX 10	Dr. Hippensteel, B	Right apical pneumothorax, 2 centimeter nodule in right lower lobe, 1 centimeter nodule in left upper lobe; consistent with sarcoidosis rather than coal workers' pneumoconiosis.

Of the six chest x-rays in the record, there is no dispute among the physicians who evaluated three of the studies that a large opacity is present.

In the June 28, 2002 film, Dr. Forehand found a category B opacity which he believed was complicated pneumoconiosis. Although Dr. Hippensteel disagreed that the large opacity indicated complicated pneumoconiosis, he nevertheless reported the presence of a 1.5 centimeter nodule.[16]

Similarly, in the September 12, 2002 radiographic study, Dr. Alexander observed a category A large opacity and associated it with complicated pneumoconiosis. Dr. Wheeler observed scattered masses in Mr. McCoy's lungs reaching 2 centimeters that he described as possible inflammatory disease or granulomatous disease. Again, even though Dr. Wheeler did not make a finding of complicated pneumoconiosis and did not describe the opacities he observed as "large," his description of opacities greater than one centimeter in diameter also establishes the presence of large opacities.

In the May 12, 2004 chest x-ray, the existence of large opacities is established even though Dr. Scatarige believes the x-ray is negative for pneumoconiosis. Because he observed a 1.5 centimeter mass in Mr. McCoy's lungs, describing an opacity greater than 1 centimeter, his interpretation establishes the presence of a large opacity. Dr. Alexander also observed the presence of category B large opacities and associated them with complicated pneumoconiosis.

Concerning the remaining three films, Dr. Mullens did not apparently find any large opacities in the December 11, 2001 chest x-ray. In the absence of any other interpretation, I conclude the December 11, 2001 chest x-ray does not establish the presence of a large pulmonary opacity.

[16] 20 C.F.R. § 718.340 (a) defines a large opacity as greater than 1 centimeter in diameter, which would be classified in Category A, B, or C under recognized classification systems. In her closing brief, counsel for the Employer essentially asserts that if a physician does not specifically define the observed mass as one of the three categories, then the reading does not represent a finding of complicated pneumoconiosis. As I noted in footnote 9, the three categories are used to define the size rather than the nature of the observed opacities.

In the October 22, 2003 chest x-ray, Dr. Pathak observed Category B large opacities that he believed were consistent with complicated pneumoconiosis. Dr. Robinette also observed Category A large opacities consistent with complicated pneumoconiosis. Dr. Scatarige did not believe that Mr. McCoy had pneumoconiosis; however, he observed a 1.5 centimeter nodule in the left upper lobe and multiple bilateral nodules ranging up to 2 centimeters. In contrast, though he commented about "mass densities," Dr. Renn did not specifically identify the size of the masses, rendering his assessment negative for the presence of large opacities. For this film, the consensus of three of the four physicians, including a dual qualified radiologist, that large opacities are present represents the preponderance of the evidence and establishes that the October 22, 2003 film is positive for a large opacity.

In the most recent chest x-ray taken on June 2, 2004, Dr. Mullens again did not report any large opacities. However, Dr. Mullens rendered that assessment as part of a fine needle lung biopsy rather than a diagnostic evaluation. In contrast, when Dr. Hippensteel evaluated the film for a pulmonary diagnosis, he again noted a two centimeter nodule in the right lower lobe and a one centimeter nodule in the left upper lobe. In light of the circumstances surrounding Dr. Mullens evaluation, I give Dr. Hippensteel's interpretation greater probative weight in determining whether large opacities are present. Based on Dr. Hippensteel's more probative assessment of this film, I conclude that the June 2, 2004 chest x-ray shows a large pulmonary opacity greater than one centimeter in diameter.

In summary, the preponderance of the radiographic evidence consisting of five of the six chest x-rays developed since the denial of Mr. McCoy's last claim (June 28, 2002, September 12, 2002, October 22, 2003, May 12, 2004, and June 2, 2004) contain evidence of a pulmonary opacity greater than 1 centimeter. Consequently, Mr. McCoy has definitively established the presence of a large opacity in his lungs through chest x-rays which is a requirement of 20 C.F.R. § 718.304 (a) for the invocation of the irrebuttable presumption of total disability due to pneumoconiosis.

Other Medical Evidence

Since Mr. McCoy has proven the existence of a large opacity, I move to the second adjudicative step added by the court in *Scarbro* and consider other relevant medical evidence prior to making a determination of whether Mr. McCoy has invoked the 20 C.F.R. § 718.304 presumption. According to the *Scarbro* court, in this second stage of the analysis, I must determine whether the preponderance of the other medical evidence affirmatively shows that large opacities in Mr. McCoy's lungs were caused by some other pathology than coal workers' pneumoconiosis. In Mr. McCoy's case, the "other" medical evidence has four components: A) other objective pulmonary test results; B) chest CT scan interpretations; C) biopsy; and, D) medical opinion based on pulmonary examination, medical record review, and evaluation of chest x-rays.

A. Pulmonary Test Results

Pulmonary Function Tests

Exhibit	**Date / Doctor**	**Age / Height**	**FEV¹ pre[17] post[18]**	**FVC pre post**	**MVV pre post**	**% FEV¹ / FVC pre post**	**Qualified[19] pre Post**	**Comments**
DX 37 & DX 38	April 20, 2001 Dr. Robinette	70 66.0″	2.54	3.66		69.4%	No[20]	Normal
DX 13	June 28, 2002 Dr. Forehand	71 67.0″	2.75	4.29	113	64.1%	No[21]	Normal ventilatory pattern
DX 37	Sept. 12, 2002 Dr. Hippensteel	71 69.0″	2.65 2.70	4.06 4.03	91	65.3%	No[22] No	
EX 1	May 12, 2004 Dr. McSharry	73 68.0″	2.78 2.90	3.91 4.23	92	67.0%	No[23] No	Essentially normal

Arterial Blood Gas Studies

Exhibit	**Date / Doctor**	**pCO^2 (rest) pCO^2 (exercise)**	**pO^2 (rest) pO^2 (exercise)**	**Qualified[24]**	**Comments**
DX 37 & DX 38	April 20, 2001 Dr. Robinette	41	81	No[25]	Normal, diffusing capacity slightly reduced

[17]Test result before administration of a bronchodilator.

[18]Test result following administration of a bronchodilator.

[19]Under 20 C.F.R. § 718.204 (b) (2) (i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718, **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

[20]The qualifying FEV1 number is 1.59 for age 70 and 65.7″; the corresponding qualifying FVC and MVV values are 2.02 and 62, respectively.

[21]The qualifying FEV1 number is 1.63 for age 71 and 66.9″; the corresponding qualifying FVC and MVV values are 2.12 and 65, respectively.

[22]The qualifying FEV1 number is 1.79 for age 71 and 68.9″; the corresponding qualifying FVC and MVV values are 2.31 and 72, respectively.

[23]The qualifying FEV1 number is 1.69 for age 71 (eldest age referenced) and 67.7″; the corresponding qualifying FVC and MVV values are 2.20 and 68, respectively.

[24]To qualify for Federal Black Lung Disability benefits at a coal miner's given pCO^2 level, the value of the coal miner's pO^2 must be equal to or less than corresponding pO^2 value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

[25]For the pCO^2 of 40 to 49, the qualifying pO^2 is 60, or less.

DX 12	June 28, 2002 Dr. Forehand	39 34	68 72	No[26] No[27]	No hypoxemia
DX 37	Sept. 12, 2002 Dr. Hippensteel	39.8 31.7	69.0 76.1	No No[28]	Normal
EX 1	May 12, 2004 Dr. McSharry	38.2	79.6	No[29]	

Discussion

In general, the objective pulmonary test evidence demonstrates Mr. McCoy does not have a significant totally disabling pulmonary impairment. Additionally, most of the physicians to evaluate that data, with the exception of Dr. Forehand, agreed the test results did not show a total respiratory impairment. As discussed later, Dr. Hippensteel and Dr. McSharry noted the absence of a pulmonary impairment as one factor in concluding that complicated pneumoconiosis was not present. However, standing alone neither pulmonary function tests nor arterial blood gas studies can specifically identify the cause of any pulmonary problem.[30] Additionally, the *Scarbro* court emphasized that the statutory scheme does not set out complicated pneumoconiosis in medical terms. Consequently, the absence of other objective medical evidence showing a total respiratory disability does not prevent invoking the presumption under 20 C.F.R. § 718.304 or impeach a finding of complicated pneumoconiosis. Accordingly, I conclude Mr. McCoy's non-qualifying pulmonary function tests and blood gas studies do not provide affirmative evidence that the large opacities in his lungs are due to some other pathology.

B. CT Scans

August 20, 2002
(DX 38)

On August 20, 2002, to evaluate the possibility of a new pulmonary nodule, Dr. Richard Mullens, board certified in diagnostic radiology, evaluated a CT scan, consisting of five millimeter intervals, conducted that day and compared the result with prior studies from December 1998 and April 2001. Dr. Mullens found a diffuse reticular nodular interstitial pattern throughout both lungs. Several small reticular nodules were located in the mid-lung zones. Dr. Mullins also noted "multiple, larger bilateral speculated nodules with adjacent parenchymal scarring and architectural distortion." While improved technology had enhanced the detail of the images, Dr. Mullens found little change from the findings of the prior studies. In closing, Dr.

[26] For the pCO^2 of 39, the qualifying pO^2 is 61, or less.

[27] For the pCO^2 of 34, the qualifying pO^2 is 66, or less.

[28] For the pCO^2 of 31, the qualifying pO^2 is 69, or less.

[29] For the pCO^2 of 38, the qualifying pO^2 is 62, or less.

[30] *See Tucker v. Director, OWCP,* 10 B.L.R. 1-35, 1-41 (1987) (pulmonary function tests and arterial blood gas studies "are not diagnostic of the etiology of an impairment, but are diagnostic only of the severity of the impairment."

Mullens stated that the "area of concern in a recent chest x-ray is not known" because he did not have the chest x-ray or report for correlation.[31]

September 12, 2002 CT Scan
(DX 37)

Dr. Kirk E. Hippensteel, board certified in pulmonary disease, interpreted a September 12, 2002 CT scan of Mr. McCoy. He observed some reticular and nodular infiltrates, more significant in lung bases than in apices. There are areas of larger nodules, mostly in the right lower lobe and one partly calcified two centimeter nodule in the left upper lobe. The nodules did not "have the distinct suggestion of coalescence as occurs with complicated coal workers' pneumoconiosis." Additionally the nodules were "not associated with an upper lobe predominance of interstitial changes expected with coal workers' pneumoconiosis." Dr. Hippensteel opined the "mostly reticular nature of abnormalities in most of [the] lung fields" was "more compatible with sarcoidosis."

May 14, 2004 PET Scan
(CX 4 and EX 10)

On May 10, 2004, Dr. Richard Mullens conducted a whole body PET scan of Mr. McCoy. Though the distribution of the radioactive material throughout the chest was mostly normal, Dr. Mullens identified "multiple foci of increased uptake in the lungs bilaterally." Three "small hypermetabolic lesions" were present in the right upper lobe. The right lower lobe contained "multiple contiguous somewhat linear shaped areas of FDG accumulation." In the left lower lobe "two very small areas of faint uptake" were present. Uptake was also present "in both hilar regions as well as mid uptake in the subcarinal region." In Dr. Mullens' opinion, the very mild uptake on the left was "probably due to the patient's CWP/silicosis." On the other hand, the "very intense hypermetabolic lesions" on the right side could "be found with either conglomerate masses associated with CWP or neoplasm." Finally, both the bilateral hilar uptake and the subcarinal uptake occur with coal workers' pneumoconiosis. For a more specific diagnosis of the largest lesion, located in the right lower lobe, Dr. Mullens believed a biopsy was necessary.

When Dr. Kirk Hippensteel attempted to interpret the stored PET scan, he found his CD copy unreadable. Upon reviewing Dr Mullens' report on the study, Dr. Hippensteel stated, "I agree with his interpretation." However, Dr. Hippensteel added, "I would note that sarcoidosis can create increased uptake as well, and he [Dr. Mullens] did not even consider such an inflammatory disease in a differential of these findings which is a significant omission."

June 2, 2004 CT Scan
(CX 4 and EX 10)

On June 2, 2004, in an effort to further evaluate the multiple lung masses and an enlarged mass in the lower right lower lobe, Dr. Richard Mullens assisted with a fine needle biopsy by

[31]In a medical record review (EX 10), Dr. Hippensteel suggested that Dr. Mullens' finding were compatible with sarcoidosis. However, Dr. Hippensteel did not actually interpret the images from this study.

using a CT scan to guide the biopsy. During the procedure, Dr. Mullens observed a right lower lobe nodule. One sample was obtained through the posterior margin of the lesion. Because Mr. McCoy then developed a small pneumothorax,[32] no additional tissue samples were taken. Images obtained after the procedure showed right pneumothorax as well as minimal parenchymal hemorrhage adjacent to the lesion.

When Dr. Kirk Hippensteel reviewed the CT scan, he observed the mass in the right lower lobe and right pneumothorax. Dr. Hippensteel explained that when Dr. Mullens performed the needle biopsy, Mr. McCoy developed a small pneumothorax during his first pass. Therefore, Dr. Mullens did not take any additional core samples. The biopsy needle point is located at the posterior edge of the right lower lobe lesion but has not penetrated the nodule. There appeared to be calcification in peripheral nodules most densely in the left upper lobe nodule and calcification in hilar and subcarinal lymph nodes. This is associated with some basilar predominant reticular nodular changes in lung fields, more consistent with a diagnosis of inflammation from sarcoidosis which affects both lung parenchyma and lymph nodes, rather than coal workers' pneumoconiosis.

Discussion

The interpretation of the CT scans, which present a minute section by section radiographic image of the lungs, corroborates the presence of large pulmonary nodules identified in the chest x-rays. While Dr. Mullens did not actually provide the specific dimensions, he nevertheless identified several nodules as large and referred to the right lower lobe mass as a conglomeration. Dr. Hippensteel also found large nodules and in one of his assessments noted a two centimeter mass in the left lobe.

Concerning the cause of the nodules, Dr. Mullens and Dr. Hippensteel have some disagreement. Although Dr. Mullens did not specifically diagnose complicated pneumoconiosis, he believed the uptake of some of the nodules in the PET scan were most likely due to pneumoconiosis/silicosis. On the other hand, the hyper-uptake of other nodules might be explainable by either pneumoconiosis or a neoplasm. Dr. Hippensteel did not refute Dr. Mullens' diagnosis of coal workers' pneumoconiosis. In fact, he stated his agreement with Dr. Mullens' reasoning on the presence of coal workers' pneumoconiosis. However, Dr. Hippensteel also faulted Dr. Mullens for not also considering the possible etiology of sarcoidosis, another inflammation lung disease. Based on the pattern and nature of the pulmonary nodules presented in the CT images, Dr. Hippensteel believes the cause of the pulmonary nodules is more likely sarcoidosis rather than coal workers' pneumoconiosis.

In light of this apparent disagreement between two uniquely qualified physicians, one a specialist in interpreting radiographic images (Dr. Mullens) and the other a pulmonary specialist (Dr. Hippensteel), who evaluated the CT images, I find the CT scan evidence, standing alone, does not definitively establish that some process other than coal workers' pneumoconiosis represents the nodules' etiology.

[32] An accumulation of air or gas in the pleural space which may occur spontaneously as a result of . . . a pathological process. DORLAND'S ILLUSTRATED DICTIONARY 1319 (28th ed. 1994).

C. Biopsy

June 2, 2004
(CX 4)

On June 2, 2004, Dr. Richard Buddington, a board certified pathologist, evaluated the tissue sample obtained from the margin of the lesion in the right lower lobe (*see* Dr. Mullens' CT scan report, dated June 2, 2004, (CX 4)). Dr. Buddington observed "scanty amounts of skeletal muscle and anthracotic pigment."

When Dr. Kirk Hippensteel reviewed Dr. Buddington's report he opined the procedure failed to isolate a cause of Mr. McCoy's breathing problems. He also noted that the needle did not penetrate the pulmonary mass and Dr. Buddington did not report even the presence of pulmonary cells in the tissue sample.

Discussion

The needle biopsy had the potential for identifying the specific nature of Mr. McCoy's pulmonary masses. Unfortunately, the development of a pneumothorax during the procedure thwarted the attempt. Although Dr. Buddington's finding of anthracotic pigment is not inconsistent with the presence of coal workers' pneumoconiosis, 20 C.F.R. § 718.202 (a) (2) states a biopsy finding of anthracotic pigmentation is insufficient to establish the presence of pneumoconiosis. As a result, Dr. Buddington's report does not provide a definitive diagnosis. Accordingly, I find the 2004 lung biopsy inconclusive in determining whether the large pulmonary masses are due to some disease unrelated to Mr. McCoy's coal mine employment.

D. Medical Opinions and Chest X-Ray Comments

Dr. Paul S. Wheeler
(DX 37)

Dr. Wheeler, a dual qualified radiologist noted in his interpretation of the September 12, 2002 chest x-ray that the nature and pattern of the opacities were consistent with granulamatous disease, metastases, inflammatory disease, or possible lymphatic spread.

Dr. Michael S. Alexander
(CX 3)

In his interpretation of the September 12, 2002 chest x-ray, Dr. Alexander noted that the large opacities were consistent with complicated coal workers' pneumoconiosis; "however, metastatic cancer could have a similar appearance."

In his interpretation of the May 1, 2004 chest x-ray, Dr. Alexander did not include the possibility of cancer.

Dr. Renn
(EX 6)

Dr. Renn opined that the masses in Mr. McCoy's lungs were consistent with metastatic disease and did not represent progressive massive fibrosis.

Dr. John C. Scatarige
(EX 1 and EX 2)

In his interpretation of the October 22, 2003 chest x-ray, Dr. Scatarige observed a 1.5 centimeter nodule in Mr. McCoy's left upper lung. He also noted interval appearance of interstitial infiltrates involving all lobes and multiple bilateral nodules 5 millimeters to 2 centimeters. His suggested diagnoses were diffuse metastatic disease, fungal disease, Wegner's disease or cytosis lymphoma. Dr. Scatarige did not believe pneumoconiosis was likely since a prior study showed no interstitial disease. He also observed the presence of emphysema.

In his interpretation of the May 12, 2004 chest x-ray, Dr. Scatarige again noted a 1.5 centimeter mass in Mr. McCoy's left upper lung, which he suggested may be granuloma. Dr. Scatarige also observed the presence of scattered nodules in the right upper and lower lobes of the lung, as well as another abnormality appearing since 1997 but not changed since 2003. His possible etiologies included chronic pneumonia, infiltrative disease, neoplasm, Wegener's disease and amyloidosis. Dr. Scatarige observed that central interstitial infiltrates had resolved since 2003. Emphysema was present in Mr. McCoy's lungs as well.

Dr. Emory Robinette
(DX 37, DX 38, and CX 4)

Dr. Robinette, board certified in internal medicine and pulmonary diseases, treated Mr. McCoy for breathing problems twice a year.[33] In June 2000 and December 2000, Dr. Robinette again saw Mr. McCoy as part of his on-going periodic treatment of Mr. McCoy's breathing problem. Upon examination, Dr. Robinette heard diminished breath sounds and an oxygen saturation of 93%. Dr. Robinette diagnosed progressive massive fibrosis with underlying coal workers' pneumoconiosis.

On June 11, 2001, Dr. Robinette noted the presence of a 2 centimeter mass in the left upper lobe of Mr. McCoy's lung established by earlier radiographic studies, which was evidence of complicated pneumoconiosis. A chest exam revealed diminished breath sounds with a few wheezes heard and mild prolonged expiratory phase. A pulmonary function test produced normal results.

[33]As background information, Dr. Robinette first treated Mr. McCoy in 1990 when he presented with breathing complaints. In the fall of 1998, Mr. McCoy was evaluated for possible metastatic lung disease when radiographic evidence showed the presence of two centimeter masses in the left upper lobe and the right lower lobe. Smaller pulmonary nodules were also present in the left lower lobe and the right middle lobe. A diagnostic bronchoscopy was negative for a malignancy (DX 38).

Dr. Robinette saw Mr. McCoy on December 11, 2001 and noted Mr. McCoy's history of black lung disease with left upper lobe lung mass, and documented pulmonary fibrosis with profusion 3/2 and type p/q opacities. A chest exam revealed diminished breath sounds with a few wheezes heard and prolongation of the expiratory phase. A pulmonary function test produced normal results.

In preparation for Mr. McCoy's hospital admission on June 2, 2004, Dr. Robinette conducted a medical examination of Mr. McCoy on May 25, 2004. Mr. McCoy was being admitted to the hospital for an elective biopsy of an enlarging right lower lung mass. Dr. Robinette believed Mr. McCoy had pneumoconiosis with a 2 centimeter nodule in the right lower lobe and 2.5 centimeter nodule in the left upper lobe. He also noted Mr. McCoy's history of pneumoconiosis with reticulonodular radiographic abnormalities, including the October 1998 diagnostic bronchoscopy evaluation which was negative for malignancy. In July 2002, an x-ray was done and consistent with pneumoconiosis, showing pulmonary nodules 1 to 2 centimeters in size.

As summarized by Dr. Robinette, a CT scan performed on August 20, 2002 demonstrated evidence of diffuse reticulonodule interstitial disease with smaller interstitial opacities, multiple large spiculated opacities and little change from a past CT scan in 1998. An x-ray from October 2003 showed an increased nodular density in the right lower lobe. A PET scan completed on May 14, 2004 and interpreted by Dr. Mullens showed multiple foci of increased uptake in the lungs bilaterally. On the left side, there was a mild area of uptake consistent with coal workers' pneumoconiosis; but on the right side there were multiple hypermetabolic lesions. Dr. Robinette told Mr. McCoy that the pattern of radiographic development may indicate a lung neoplasm. As a result, Dr. Robinette suggested a diagnostic needle biopsy of the right lung mass. A chest exam at this time revealed diminished breath sounds without significant bronchospasm and prolonged expiratory phase. Dr. Robinette diagnosed complicated coal workers' pneumoconiosis and an enlarging right lower lung mass.

Dr. J. Randolph Forehand
(DX 14 and DX 16)

On June 28, 2002, Dr. Forehand, board certified in pediatrics, allergy and immunology, conducted a pulmonary evaluation of Mr. McCoy who reported sputum, wheezing and dyspnea. Mr. McCoy had a coal mine employment history of 28 1/2 years. He smoked 3-4 cigars and 6 to 8 pipes full of tobacco per day from 1948 to 1968. Dr. Forehand heard rare crackles in the bases of Mr. McCoy's lungs. In the chest x-ray, Dr. Forehand observed complicated coal workers' pneumoconiosis with large category B opacities. The pulmonary function test was normal and the arterial blood gas study revealed no abnormalities. Dr. Forehand diagnosed complicated pneumoconiosis caused by coal dust exposure. The physician believed that the complicated pneumoconiosis caused serious damage to Mr. McCoy's lungs which rendered him totally and permanently disabled and unable to return to his previous coal mining job. No other lung disease contributed to Mr. McCoy's total disability.

Dr. Kirk Hippensteel
(DX 37, EX 7 and EX 10)

On September 12, 2002, Dr. Hippensteel, board certified in internal medicine, pulmonary disease and critical care, conducted a pulmonary evaluation of Mr. McCoy who reported breathing problems since 1971, which causes him to become short of breath after climbing more than one flight of stairs. Mr. McCoy was a coal miner for 31 years, stopping in October 1986. While employed in the coal mines, he was a roof bolter and shoveled coal, which required heavy labor. Mr. McCoy gets rare upper respiratory infections but has never had pneumonia, TB (tuberculosis) or been hospitalized for his breathing problems. He has never had bird or chicken exposure. From 1946 to 1968, Mr. McCoy smoked 5 to 6 cigars and 3 to 5 pipes full of tobacco per day. A chest exam revealed a mild increase in AP chest diameter with minimal scattered rales in bases. The pulmonary function test and arterial blood gas study produced normal results.

A chest x-ray was taken and interpreted by Dr. Wheeler who found scattered 5 millimeter to 2 centimeter masses in the lungs compatible with granulamatous disease or metastasis. Based on his review of a CT scan, Dr. Hippensteel believed that the nodules do not have the distinct suggestion of coalescence as occurs with complicated coal workers' pneumoconiosis and are not associated with upper lobe predominance of interstitial changes expected from pneumoconiosis. The mostly reticular nature of abnormalities was more consistent with sarcoidosis. Mr. McCoy's angiotensin converting enzyme ("ACE") level was elevated to 87,[34] consistent with a diagnosis of sarcoidosis, which is a granulamatous disease. The angiotensin enzyme level is not usually elevated with coal workers' pneumoconiosis. For these reasons, Dr. Hippensteel concluded that the abnormalities on x-ray were most compatible with nodular sarcoidosis, which is a noninfectious granulomatous disease of the lungs, unrelated to coal mine dust exposure. "It is variable in its effects on lung function when present." Its presence has not caused any ventilatory or gas exchange impairment. As a result, Mr. McCoy does not have any pulmonary impairment that would prevent him from going back to his previous job in the mines.

After reviewing an extensive medical record dating back to 1972, Dr. Hippensteel concluded that the disease process in Mr. McCoy's lungs is not consistent with coal workers' pneumoconiosis because there was no progression of the disease. Dr. Hippensteel explained:

> Even though coal workers' pneumoconiosis can be progressive after leaving work in the mines, this case shows that it did not progress significantly during active exposure, and then when there was radiographic progression, it was not associated with any development of pulmonary function abnormalities, which would not be expected with rapidly progressive massive fibrosis.

Instead, most of the findings are consistent with sarcoidosis; although it appears there has also been an unrelated granulamatous process in the left upper lobe. While Dr. Hippensteel acknowledges that Mr. McCoy may have simple pneumoconiosis, he does not believe Mr. McCoy has progressive massive fibrosis or a total disability that would prevent him from returning to his previous coal mine employment.

[34]According to the medical report, the normal range is 8 to 52 (DX 37).

In a deposition conducted on May 24, 2004, after reviewing additional medical records, Dr. Hippensteel testified about his September 2002 evaluation of, medical conclusions regarding, Mr. McCoy. The arterial blood gas study conducted by the physician showed normal results that even improved with exercise. The pulmonary function test was also normal. These results were consistent with the studies taken by Dr. Robinette in April 2001 and Dr. Forehand in June 2002. Mr. McCoy's breathing test results were even better with Dr. McSharry, who Mr. McCoy saw a year and a half after he saw Dr. Hippensteel.

Dr. Wheeler interpreted the chest x-ray taken as part of Dr. Hippensteel's examination. The mass noted by Dr. Wheeler in Mr. McCoy's left lobe dates back to 1970 in the medical records. Based on his review of the CT scan, Dr. Hippensteel concluded that the abnormalities present in Mr. McCoy's chest were more compatible with granulamatous disease secondary to sarcoidosis rather than coal workers' pneumoconiosis for several reasons.

First, the multiple radicular and nodular infiltrates were more significant in the lung bases. That location is not consistent with coal workers' pneumoconiosis which causes "a predominance in the upper lobes."

Second, the radicular nature of the nodules is "more compatible with sarcoidosis. Coal workers' pneumoconiosis produces a "more nodule pattern."

Third, the larger nodules did not have "any distinct suggestion of coalescence" as would be expected if it were complicated pneumoconiosis. These large nodules also were not associated with any upper lobe predominance of interstitial changes. In particular, the calcified nodule in the left upper lobe, which has been present since the 1970's, was not referable to a large opacity from pneumoconiosis. If the mass in the left upper lobe was related to a chronic dust disease of the lung and coal mine employment, it would be a category A opacity. In that case, Dr. Hippensteel would not have expected the mass to stay the same size from 1971 to 1986. Usually with coal workers' pneumoconiosis, a coalescence of smaller opacities occurs, which in turn makes the mass larger over time.

Fourth, detailed images from the CT scan coupled with the angiotensin converting enzyme elevated levels, point to a granulamatous disease. A granulamatous disease occurs when the lung reacts to an infection or "certain inflammatory agents" by encasing the irritant and causing a lesion. It will produce calcification over time. There are many types of granulamatous disease, including tuberculosis, fungal disease, and sarcoidosis. However, coal workers' pneumoconiosis is not a granulamatous disease because it does not produce the same type of reaction in the lung.

Fifth, Mr. McCoy's lack of pulmonary function problems as the radiographic changes progressed, the absence of radiographic changes during Mr. McCoy's continued exposure to coal dust, and the onset of radiographic changes only after he left the mines led Dr. Hippensteel to conclude that Mr. McCoy does not have simple or complicated pneumoconiosis, or that the larger masses are in any way related to a chronic dust disease of the lung. Although progression of coal workers' pneumoconiosis can occur after a miner has left the mines, it is expected that it would at least occur close to the time that the miner was working in the mines.

Dr. Scatarige interpreted the October 22, 2003 chest x-ray suggesting the presence of cytosis lymphoma, which is a granulamatous disease; however, with all of the other medical evidence of record, Dr. Hippensteel does not believe that is a correct diagnosis. Dr. Scatarige also mentioned Wegener's and amyloidosis as possible diagnoses, both diseases that create a nodular pattern in the lung like coal workers' pneumoconiosis.

To determine what specific granulamatous disease Mr. McCoy had, Dr. Hippensteel conducted an angiotensin converting enzyme test, which showed an elevated level indicative of sarcoidosis. Although the test "is not completely specific" for sarcoidosis, an high level increases the likelihood that sarcoidosis is present. Though a person can have an elevated level from this test and not have sarcoidosis; coal workers' pneumoconiosis does not cause an elevated level.

Based on all of these findings and reasons, Dr. Hippensteel believes sarcoidosis is the "probable reason" for elevation of the enzyme level. The mass in Mr. McCoy's left upper lobe, which has been present for 30 years does not appear to be the result of sarcoidosis, but rather "some other granulamatous process, possibly infectious from histoplasmosis or something like that." Dr. Hippensteel also concludes that Mr. McCoy does not have a respiratory impairment and can return to his previous coal mining job. The cause of the x-ray abnormalities is sarcoidosis and possibly another type of granulamatous disease, which is not related to coal mine dust.

On July 1, 2004, Dr. Hippensteel reviewed additional medical records including Dr. Robinette's treatment notes, a CT scan conducted on August 20, 2002 by Dr. Mullens, the chest x-ray interpretations by Dr. Wheeler and Dr. Alexander of the September 2002 film and interpretations by Dr. Pathak, Dr. Renn, Dr. Robinette and Dr. Scatarige of the October 2003 film, Dr. McSharry's May 2004 medical report and report of June 2004 hospital admission, including the needle lung biopsy attempt.

In regards to the biopsy, Dr. Hippensteel concluded the procedure failed to produce any "meaningful" result. The biopsy did not identify any cause for the lung masses. Dr. Hippensteel further concluded that the physicians who cared for Mr. McCoy were working under a preconception that Mr. McCoy had coal workers' pneumoconiosis and did not evaluate the evidence to see if another diagnosis was more appropriate. In particular, he faulted the physicians for failing to include sarcoidosis in their consideration of etiology. Dr. Hippensteel continues to believe that sarcoidosis is the "probable diagnosis."

Dr. Roger G. McSharry
(EX 1 and EX 8)

On May 12, 2004, Dr. McSharry, board certified in internal medicine, pulmonary disease and critical care, conducted a pulmonary evaluation of Mr. McCoy. Mr. McCoy reported a 31 year history of coal mining, 28 years of which were underground. His last job in mining was as a roof bolter, where he did moderately strenuous work setting jacks. He stopped working in 1986 due to shortness of breath and back problems. He smoked 8 to 9 cigars a day and 3 to 4 pipefuls of tobacco a day for 15 to 18 years before quitting permanently in 1968. Mr. McCoy is

able to walk on level ground slowly but has difficulty going up hills and stairs because of shortness of breath. The chest examination was normal and breath sounds were clear. The chest x-ray interpretation by Dr. Scatarige was negative for pneumoconiosis. The pulmonary function test and arterial blood gas study were normal. Dr. McSharry concluded that Mr. McCoy had significant coal dust exposure and exertional dyspnea without strong suggestion of asthmatic component.

Dr. McSharry also reviewed medical records dating back to 1971 in addition to CT scans from 1998, 1999, 2002 and 2004 He noted that the left upper lobe nodule had not progressed over the years. Likewise, many of the other nodules in the right and left lung had not changed. At the same time, "[t]he right mid lung zone shows some progressive enlargement of nodules into a more confluent mass over the time since 1998."

Upon review of all the evidence, Dr. McSharry believed the evidence was inadequate to justify a diagnosis of coal workers' pneumoconiosis. Although Mr. McCoy had mined coal for many years, the chest x-rays did not show typical abnormalities associated with coal workers' pneumoconiosis – "rounded nodularity predominating the upper lung zones." Rather, the multiple round densities in the periphery of Mr. McCoy's lungs are most suggestive of pulmonary granulomas as well as the larger lesions in the left upper lung zone which are unchanged over time and the progressive abnormalities in the right mid and lower lung zones, which are consistent with granulomatous disease. Dr. McSharry also bases his finding that Mr. McCoy does not have coal workers' pneumoconiosis on his normal pulmonary function tests. It would be unusual for a person with coal workers' pneumoconiosis with progressive massive fibrosis to have normal function tests.

In addition, Dr. McSharry observed the lack of evidence showing either an obstructive or restrictive lung disease. Thus, Mr. McCoy does not have a pulmonary disability; there is no reason he could not return to his previous coal mine employment. Dr. McSharry believes that the abnormalities seen on chest x-rays, "in all likelihood represent some form of granulomatous lung disease, either from old infection or possibly from another process such as pulmonary sarcoidosis." However, Dr. McSharry explained that "the elevated angiotensin converting enzyme level mentioned in the record does not definitely prove sarcoidosis, and [he] could not with any certainty say that these lesions represent pulmonary sarcoidosis, but that is a possibility." Finally, with respect to the left upper lobe mass seen radiographically for 30 years, this lesion cannot "reasonably be attributed" to a lesion of progressive massive fibrosis since it has not progressed during Mr. McCoy's life.

In a deposition conducted on June 3, 2004, Dr. McSharry testified about his medical conclusions regarding Mr. McCoy's medical condition. Dr. McSharry stated that the pulmonary function and arterial blood gas tests conducted by him and other physicians in the record around that time did not show any respiratory disability. Consequently, he would not place any restrictions on Mr. McCoy's ability to do heavy manual labor. Moreover, the lesions that Dr. McSharry observed on CT scans and chest x-rays were not consistent with the type associated with coal mine dust exposure. The pulmonary nodules, which changed over time are more representative of cancers and granulomatous diseases, which is distinct from changes seen with pneumoconiosis. Pneumoconiosis is a fibrotic disease, not a granulamatous disease. It is

common for a person to have abnormalities from granulamatous disease and not have a history of being seriously ill.

"The most common presentation" of sarcoidosis "is enlarged lymph glands in the chest with no symptoms whatsoever." Sarcoidosis can also cause other abnormalities in the lungs, including nodules that are either stable or change over time, with or without evidence of impairment of lung function. Sarcoidosis can cause an elevated angiotensin enzyme level in a person but it does not always. Some reports have found coal workers' pneumoconiosis causing an elevated level of the enzyme as well. The evidence is not clear and Dr. McSharry doesn't believe pneumoconiosis will cause elevated levels. At the same time, Dr. McSharry can not diagnose sarcoidosis without a biopsy that showed the lesions look like sarcoidosis because Mr. McCoy "is not the most typical case of sarcoidosis."

Dr. McSharry concurs with Dr. Hippensteel's finding that the old lesion in the left upper lobe of the lung is unrelated to the other lesions in Mr. McCoy's lungs. Dr. McSharry does not believe the lesion is caused by coal mine dust exposure because he would expect there to be other abnormalities associated in the localized area with the lesion which would evolve and worsen over time with continued exposure to coal mine dust. Additionally, he would expect changes in the left lobe lesion would occur closer to 1986 when Mr. McCoy was still working in the mines, rather than long after his coal mine employment ended.

Dr. McSharry testified that that he "would expect that there would be a fair amount of abnormality in the lung function if there was that sort of distortion of lungs going on because [of] coal dust exposure." Granulomas generally do not impair lung function. Dr. McSharry does not think that Mr. McCoy has simple coal workers' pneumoconiosis or complicated pneumoconiosis or progressive massive fibrosis. However, if Mr. McCoy had simple coal workers' pneumoconiosis, Dr. McSharry would "concede the possibility" that some of the larger lesions that evolved over time could be related to that even though they are not typical of pneumoconiosis. None of the masses, neither the one in the left upper lobe nor the ones in the mid and lower lobes, are due to a chronic dust disease of the lungs. Dr. McSharry does not think that Mr. McCoy has any respiratory impairment and believes he could return to his last coal mining job based on his pulmonary system. If Mr. McCoy had never worked in the mines, he would still have the same x-ray abnormalities.

Discussion

Prior to considering this extensive array of medical opinion, another review of the adjudication principles applicable within the jurisdiction of the U.S. Court of Appeals for the Fourth Circuit on the issue of complicated pneumoconiosis is helpful. First, the congressionally defined criteria – a radiographic opacity present in the lungs greater than one centimeter – represents the most objective means for establishing the presence of complicated pneumoconiosis.[35] Second, in light of this congressional mandate, the statutory definition of complicated pneumoconiosis controls over the medical definition of the same disease. Third,

[35]Interestingly, the U.S. Court of Appeals for the Sixth Circuit has reached a contrary conclusion. In *Gray v. SLC Coal Co.*, 176 F.3d 382, 389-390 (6th Cir. 1999), the court commented, "x-rays are generally recognized as the least accurate method of correctly diagnosing complicated pneumoconiosis."

although all relevant and conflicting medical evidence must be considered, radiographic evidence showing the presence of one or more opacities greater than one centimeter loses probative force in establishing the presence of complicated pneumoconiosis only by an affirmative showing that a) the large opacity is not actually present due to either technical equipment problems or incompetence associated with the interpretation; or b) the large opacity is not what it seems to be (complicated pneumoconiosis) due to some other intervening pathology.

With these principles in mind, I first note that no physician has questioned the accuracy of the radiographic images showing large opacities greater than one centimeter.

Since the radiographic images of large opacities are accurate, the physicians who have evaluated the Mr. McCoy's pulmonary condition have focused on the cause of the opacities and obviously reached contrary conclusions. Dr. Alexander, Dr. Robinette, and Dr. Forehand diagnosed complicated pneumoconiosis. Dr. Wheeler, Dr. Renn, Dr. Scatarige, Dr. McSharry, and Dr. Hippensteel believed some disease process, other than pneumoconiosis, has produced the radiographic opacities. Due to the conflict of medical opinion, I must assess the relative probative value of the opinions based on documentation and reasoning.

A physician's medical opinion is likely to be more comprehensive and probative if it is based on extensive objective medical documentation such as radiographic tests and physical examinations. *Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter. Finally, in light of the extensive relationship a treating physician may have with a patient, the opinion of such a doctor may be given greater probative weight than the opinion of a non-treating physician. *See Downs v. Director, OWCP*, 152 F.3d 924 (9th Cir. 1998) and 20 C.F.R. §718.140 (d).

The second factor affecting relative probative value, reasoning, involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's reasoning that is both supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988).

Since Dr. Wheeler, Dr. Renn, Dr. Alexander, and Dr. Scatarige, essentially based their etiology opinions only the radiographic images before them, their conclusions are less documented than the evaluations of other doctors who considered both the radiographic interpretations and other objective medical evidence. Thus, for example, Dr. Alexander was not aware of the elevated ACE test which might be indicative of sarcoidosis. Similarly, Dr. Wheeler, Dr. Renn, and Dr. Scatarige were not aware of the PET scan results showing mild uptake in multiple nodules which may be consistent with pneumoconiosis or Dr. Buddington's finding of anthracotic pigmentation, which though not a definitive finding of pneumoconiosis is nevertheless not inconsistent with the presence of pneumoconiosis.

In terms of reasoning, Dr. Alexander introduced some ambiguity into his assessment by indicating in at least one interpretation that the images could represent either black lung disease or metastatic cancer. Likewise, though Dr. Wheeler, Dr. Renn, and Dr. Scatarige dismissed pneumoconiosis as an etiology based on the nature and pattern of the opacities, their multiple alternative diagnoses, including granulamatous disease, metastatic disease, inflammatory disease, lymphoma, and fungal disease, hardly represents an affirmative showing that some other specific pulmonary disease has produced the large pulmonary opacities. Thus, for both documentation and reasoning shortfalls, the opinions of Dr. Wheeler, Dr. Renn, Dr. Alexander, and Dr. Scatarige have diminished probative value.

Dr. Forehand's finding of complicated pneumoconiosis is also not as well documented as other opinions because he appears to have relied solely on the results of one pulmonary evaluation of Mr. McCoy. Thus, Dr. Forehand was not aware of the series of chest x-ray interpretations and associated changes in the nature and pattern of the pulmonary nodules, the PET scan results, the elevated ACE test result, or the June 2004 biopsy finding. As result, though well reasoned within the context of Mr. McCoy's examination, Dr. Forehand's opinion has less relative probative weight than the more fully documented assessments.

As his long-term treating physician and a board certified pulmonologist, Dr. Robinette had an extensive documentation foundation for his conclusion that Mr. McCoy has complicated pneumoconiosis. Dr. Robinette examined Mr. McCoy on multiple occasions and was well aware of his radiographic history, the PET scan results and the biopsy test. The only documentary shortfall appears to be his lack of knowledge about the high ACE level Dr. Hippensteel discovered. However, as discussed later, the significance of that one piece of information is lessened based on the dispute between Dr. Hippensteel and Dr. McSharry as to the definitive meaning of the test result.

On the other hand, concerning his reasoning, since his conclusions are presented in treatment notes, Dr. Robinette's opinion is not as well explained as the assessments by Dr. Hippensteel and Dr. McSharry. Additionally, as noted by Dr. Hippensteel, Dr. Robinette apparently narrowed his consideration of etiologies for the large opacities to complicated pneumoconiosis or neoplasm.

In a documented opinion, and as a well qualified pulmonary physician, Dr. McSharry addressed the etiology of the large nodules by a) indicating that Mr. McCoy did not have complicated pneumoconiosis; and b) diagnosing granulamatous disease. However, several aspects of his reasoning diminish the probative value of his conclusion. One of the principal factors, Dr. McSharry relied upon in determining that Mr. McCoy did not have complicated pneumoconiosis was the absence of a totally disabling pulmonary impairment. Highlighting the normal results from Mr. McCoy's pulmonary function tests and the arterial blood gas studies, and the absence of either a restrictive or obstructive pulmonary impairment, Dr. McSharry indicated he would not expect a person with coal workers' pneumoconiosis with progressive massive fibrosis to have such normal results. While his reasoning may make medical sense, the court of appeals emphasized that the legal definition controls over the medical definition. In that light, Dr. McSharry's implicit requirement that a disabling pulmonary impairment must exist in order to establish complicated pneumoconiosis is contrary to the statutory definition of the

disease. Neither the statute nor the implementing regulation impose a prerequisite of a pulmonary impairment to establish the presence of complicated pneumoconiosis.

In eliminating complicated pneumoconiosis as a possible cause of the opacities, Dr. McSharry also emphasized that Mr. McCoy did not have simple coal workers' pneumoconiosis because the smaller, multiple opacities were present in the peripheral portions of the lungs rather than the upper zone where pneumoconiosis usually develops. This distinction was important to Dr. McSharry because he stated that if Mr. McCoy did have coal workers' pneumoconiosis, he could concede the possibility that the larger radiographic nodules developed over time could be related to coal dust exposure. Dr. McSharry's use of the opacities' location as a discriminating consideration raises a reasoning concern. Once again, while his reasoning may have a sound medical foundation, Dr. McSharry's analysis runs contrary to the regulatory definition of pneumoconiosis. According to 20 C.F.R. § 718.1002 (b), a chest x-ray may establish pneumoconiosis if the profusion is classified as 1, 2, or 3 according to the ILO standards. In turn, the ILO chest x-ray form permits the profusion of small opacities to be located in all six lung zones rather than just the two upper zones specified by Dr. McSharry.

Further, in identifying the cause of the large opacities, and having eliminated pneumoconiosis, Dr. McSharry focused on the location of the opacities and the absence of a pulmonary impairment to diagnose an unspecified granulamatous disease. That diagnosis is undermined legally for the reasons discussed above and thus has diminished probative value.

In perhaps the best documented opinion, Dr. Hippensteel, another well qualified pulmonologist, presented an extensive and exhaustive explanation on why Mr. McCoy a) did not have complicated pneumoconiosis; and, b) had sarcoidosis. In concluding the larger opacities did not represent complicated pneumoconiosis, Dr. Hippensteel relied on several factors. First, Mr. McCoy did not have complicated pneumoconiosis because the large opacities were not associated with any interstitial changes in the upper lung zones. Second, Mr. McCoy did not experience a pulmonary impairment as the radiographic changes were developing. Third, if the large opacities were related to coal dust, Dr. Hippensteel would expect the development of the opacities to occur while Mr. McCoy was still mining coal. Instead, Mr. McCoy did not experience any radiographic changes until after he left coal mining. Though the progression of coal workers' pneumoconiosis can occur after a miner leaves the coal mines, Dr. Hippensteel expects the disease to develop close to the time the person was a coal miner. Fourth, the reticular nature of the opacities and absence of coalescence of the opacities into larger masses, in particular the larger left upper lung nodule, pointed to some cause for the larger opacities other than pneumoconiosis.

In weighing the probative value of his conclusion that the opacities are not due to pneumoconiosis, I believe the first three discriminating factors emphasized by Dr. Hippensteel raise reasoning concerns. As previously discussed in regards to Dr. McSharry's opinion, Dr. Hippensteel's reliance on the location of the opacities and the absence of a pulmonary impairment as distinguishing features adversely affects the probative value of his conclusion. I also note that contrary to Dr. Hippensteel's interpretation, some radiologists and physicians found pneumoconiosis nodules in the upper zones, essentially rendering the radiographic evidence on the location of pneumoconiosis nodules in the upper lung lobes inconclusive rather

than the certainty relied upon by Dr. Hippensteel. Dr. Hippensteel's observation about development timing of the large opacities is also problematic. According to 20 C.F.R. § 718.201 (c), pneumoconiosis is a "latent" disease that may be detectable some time after a person stops mining coal.[36] No requirement exists that pneumoconiosis begin to develop during employment as a coal miner or some time soon after the cessation of coal mining.

Based on the nature of the pulmonary opacities and relying on an elevated ACE test result, Dr. Hippensteel diagnosed sarcoidosis. Because coal workers' pneumoconiosis did not cause an elevation in ACE levels, Dr. Hippensteel was fairly convinced that Mr. McCoy's large pulmonary opacities were due to sarcoidosis. Standing alone, and within the context of his evaluation, Dr. Hippensteel's conclusion is reasoned. However, and significantly, another similarly well qualified physician, Dr. McSharry, also considered whether sarcoidosis caused the large opacities. Unlike Dr. Hippensteel, Dr. McSharry was unable to render a sarcoidosis diagnosis. Based on some studies showing a link between elevated ACE and pneumoconiosis, Dr. McSharry considered the ACE test result and the other objective medical evidence inconclusive. Dr. McSharry would require a biopsy prior to rendering a diagnosis of sarcoidosis. Additionally, according to Dr. McSharry, sarcoidosis usually caused enlarged lymph nodes. Such a medical finding was not present in Mr. McCoy's case. Consequently, Dr. McSharry did not think Mr. McCoy had the typical case of sarcoidosis. Although Dr. McSharry's opinion does not necessarily outweigh Dr. Hippensteel's assessment, it provides sufficient contrary evidence to preclude giving Dr. Hippensteel's diagnosis of sarcoidosis definitive probative weight.

Conclusion

For diverse reasoning issues, none of the better documented opinions of Dr. Robinette, Dr. McSharry, and Dr. Hippensteel stands out as the definitive diagnosis of Mr. McCoy's large pulmonary opacities. Considering their assessments in light of the objective medical test showing enlarging nodules, inconclusive evidence of simple coal workers' pneumoconiosis, inconclusive ACE test results, PET scan uptakes consistent with both pneumoconiosis and granulamatous disease, and a biopsy finding of anthracotic pigment, I conclude the medical record is sufficiently conflicted and inconclusive such that an affirmative showing that the radiographic large opacities are due to an intervening pathology has not been established.

Mr. McCoy's chest x-rays vividly establish the presence of large opacities as defined by the Act. At the same time, neither the other objective medical tests, CT scan interpretations, biopsy result, nor physician opinion provide sufficient affirmative showing of an intervening pathology to diminish the probative value of the radiographic large opacities as complicated pneumoconiosis. Accordingly, I conclude Mr. McCoy is able to invoke the presumption under 20 C.F.R. § 718.304 through radiographic evidence of large pulmonary opacities and the absence of other medical evidence that affirmatively establishes another cause for the opacities unrelated to coal dust exposure.

[36]*See also Parsons v. Wolf Creek Colleries*, 23 B.L.R. 1-_____, BRB No. 02-0188 BLA (Sept. 30, 2004) (*en banc*) (the potential for progressivity and latency of pneumoconiosis is inherent in every case) and *Workman v. Eastern Assoc. Coal Corp*., BRB No. 02-0727 BLA (Aug. 19, 2004) (order on recon.) (*en banc*).

Through the invocation under 20 C.F.R. § 718.304, Mr. McCoy has proven that he is totally disabled due to pneumoconiosis, thereby establishing that one of the conditions of entitlement that he previously failed to prove (total disability) has changed and is now present. As a result, under 20 C.F.R. § 725.309, I must now examine the entire medical record to determine whether Mr. McCoy is entitled to benefits under the Act.

Issue # 2 – Entitlement to Benefits

As previously discussed, to receive benefits under the Act, Mr. McCoy must prove that he has a) pneumoconiosis b) that arose out of his coal mine employment and that he is c) totally disabled d) due to coal workers' pneumoconiosis.

Pneumoconiosis

"Pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment.[37] The regulatory definitions include both clinical, or medical pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as "any chronic lung disease arising out of coal mine employment."[38] The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. § 718.201 (b). As courts have noted, under the Act, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. § 718.202, the existence of pneumoconiosis may be established by four methods: chest x-ray (§ 718.202 (a) (1)), autopsy or biopsy report (§ 718.202 (a) (2)), regulatory presumption (§ 718.202 (a) (3)), and medical opinion (§ 718.202 (a) (4)). One of the regulatory presumptions specified by 20 C.F.R. § 718.203 (a) (3) is the irrebuttable presumption under 20 C.F.R. § 718.304, relating to the presence of complicated pneumoconiosis. Since Mr. McCoy has now invoked that presumption of total disability due to pneumoconiosis, he has proven the presence of pneumoconiosis under 20 C.F.R. § 718.202 (a) (3).

According to the U.S. Court of Appeals in *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000), on the issue of pneumoconiosis, I must consider all the chest x-ray evidence and medical opinion together to determine whether a claimant can establish pneumoconiosis.

Since my determination on the issue of the presence of complicated pneumoconiosis required consideration of the medical record in the present claim, including chest x-rays, CT scans, pulmonary testing, and medical opinion, I believe the *Compton* evidentiary considerations requirement have also been satisfied. Further, my review of the earlier medical evidence in the prior claims provided little relevant contrary information on the present state of Mr. McCoy's pulmonary condition. Thus, Mr. McCoy has proven that he has pneumoconiosis.

[37]20 C.F.R. § 718.201 (a).

[38]20 C.F.R. § 718.201 (a) (1) and (2).

Pneumoconiosis Arising Out of Coal Mine Employment

Having proven the presence of pneumoconiosis, Mr. McCoy must next establish that his pneumoconiosis arose, at least in part, out of coal mine employment. According to 20 C.F.R. §718.203 (b), if a miner who is suffering from pneumoconiosis was employed for ten years or more in one or more coal mines, there is a rebuttable presumption that pneumoconiosis arose out of such employment. Since Mr. McCoy has at least 28 years of coal mine employment, he is entitled to the regulatory presumption.

Because the presumption of pneumoconiosis arising out of coal mine employment is rebuttable, I must reexamine the medical record to determine whether sufficient evidence exists to sever the presumptive connection between Mr. McCoy's pneumoconiosis and his coal mine employment. The medical evidence contained in the earlier claims with multiple modification requests provides little relevant information on whether the pneumoconiosis which Mr. McCoy has now developed is due to some cause other than coal mining. In the present claim, the medical opinions of Dr. Hippensteel and Dr. McSharry, along with the x-ray comments by Dr. Wheeler and Dr. Scatarige suggest other causes unrelated to coal dust exposure for the presence of the large opacities. However, I have already determined that their opinions do not sufficiently establish a non-coal dust related pathology. As a result, the causation presumption under 20 C.F.R. § 718.203 (b) has not been rebutted and I find that Mr. McCoy's pneumoconiosis is due to his coal mine employment.

Total Disability and Total Disability Due to Pneumoconiosis

The last two requisite elements of entitlement are total disability and total disability due to coal workers' pneumoconiosis. Having invoked the 20 C.F.R. §§ 718.304 and 718.203 (b) presumptions, Mr. McCoy has also established these two necessary components for receipt of benefits under the Act.

Conclusion

Based on the presence of large opacities in the chest x-rays submitted since Mr. McCoy's claim was last denied in March 2001, and in the absence of sufficient affirmative evidence showing a non-coal dust related cause, Mr. McCoy has invoked the irrebuttable presumption of total disability due to pneumoconiosis under 20 C.F.R. § 718.304. That invocation also establishes the presence of pneumoconiosis under 20 C.F.R. § 718.202 (a) (3). Finally, through the presumption in 20 C.F.R. § 718.203 (b), with at least 28 years of coal mine employment, Mr. McCoy is able to establish that his pneumoconiosis was due to his coal mine employment. Having proved each requisite element of entitlement, Mr. McCoy has met his burden of proof and his claim must be approved.

Issue No. 3 – Onset Date of Total Disability and Responsible Operator

Under 20 C.F.R. § 725.503 (b) in the case of a coal miner who is totally disabled due to coal workers' pneumoconiosis, benefits are payable from the month of onset of total disability. When the evidence does not establish when the onset of total disability occurred, then benefits

are payable starting the month the claim was filed. However, according to 20 C.F.R. § 725.309 (d) (5), when a subsequent claim is awarded, no benefits may be paid for any period prior to the date upon which the prior claim denying the prior claim became final. In Mr. McCoy's case, the denial of his prior claim became final in April 2001 when he did not appeal the adverse decision.

The BRB has placed the burden on the miner to demonstrate the onset of total disability. *Johnson v. Director, OWCP*, 1 B.L.R. 1-600 (1978). Placing that burden on the claimant makes sense, especially if the miner believes his total disability arose prior to the date he filed his claim. In that case, failure to prove a date of onset earlier than the date of the claim means the claimant receives benefits only from the date the claim was filed. The BRB also stated in *Johnson*, "[c]learly the date of filing is the preferred date of onset unless evidence to the contrary is presented."

At the same time, a miner may not receive benefits for the period of time after the claim filing date during which he was not totally disabled. *Lykins v. Director, OWCP*, 12 B.L.R. 1-181, 1-183 (1989). This principle may come into play if evidence indicates there was a period of time after the filing of the claim during which the miner was not totally disabled. One example is the situation in *Rochester and Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600 (3d Cir. 1989) where after the miner filed his claim, the initial probative medical opinions provided some evidence that the miner was not totally disabled, yet the administrative law judge found a subsequent evaluation did establish total disability and then set the entitlement date as the date of the claim. The appellate court affirmed the finding of total disability but believed the administrative law judge erred by awarding benefits from the date of the claim because he had not considered whether the earlier medical evaluations indicated that the pneumoconiosis had not yet progressed to a totally disabling stage. In other words, if evidence shows an identifiable period of time where a miner was not totally disabled by pneumoconiosis that is subsequent to the date the miner filed his claim and prior to a firm medical determination of total disability, then it is inappropriate to award benefits from the month the claim was filed.

However, if no intervening medical evidence raises the possibility of total disability not being present between the claim filing date and the first medical evaluation establishing total disability, then a different set of principles is applicable. In this situation, when the first medical examination after the claim is filed leads to a finding of total disability, the date of the examination does not necessarily establish the month of onset of total disability. Instead, it only indicates that some time prior to the exam, the miner became totally disabled. *See Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1985) (the date the claimant is "first able to muster evidence of total disability is not necessarily the date of onset").

Mr. McCoy filed his present claim on April 22, 2002 and he has established his total disability based on complicated pneumoconiosis established by the presence of a large pulmonary opacities. The only evidence in the record for the period between the denial of his prior claim in March 2001 and his new claim in April 2002 is a chest x-ray from December 2001. However, that film did not establish the presence of a large opacity. Instead, the first radiographic evidence of a large opacity associated with Mr. McCoy's second claim occurred on June 28, 2002. At the same time, no evidence exists to indicate that the large opacities were not present in his lungs between the time Mr. McCoy filed his second claim in April 2002 and the

June 2002 chest x-ray. Consequently, I find the date of entitlement and onset of total disability is April 1, 2002.

In its closing brief, the Employer has contested its liability as responsible operator for any disability benefits that may be payable to Mr. McCoy due to the presence of complicated pneumoconiosis. If Mr. McCoy is deemed to have complicated pneumoconiosis based on the presence of large pulmonary opacities, then he has been totally disabled due to coal workers' pneumoconiosis since 1971 when a large opacity was first identified. The presence of that large opacity and associated total disability predates Mr. McCoy's employment with Holly Beth Coal in 1983. As a result, in accordance with *Truitt v. North American Coal Co.,* 2 B.L.R. 1-199 (1979), Holly Beth Coal is not liable for disability benefits because Mr. McCoy's employment with the company did not cause his disability.[39]

Since I have determined that Mr. McCoy did not become totally disabled due to coal workers' pneumoconiosis until April 2002, the *Truitt* case is not applicable. As the last employer to employ Mr. McCoy for more than one year as a coal miner, Holly Beth Coal is the appropriate responsible operator and consequently liable for the payment of Mr. McCoy's black lung disability benefits.

ORDER

The claim of MR. JAMES MCCOY, JR. for benefits under the Act is **GRANTED**. HOLLY BETH COAL, INC. and ROCKWOOD INSURANCE COMPANY are ordered to pay Mr. James McCoy, Jr. all benefits to which he is entitled under the Act and Regulations. Benefits shall commence April 1, 2002.

SO ORDERED:

A

Richard T. Stansell-Gamm
Administrative Law Judge

Date Signed: June 7, 2005
Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision is filed with the District Director, Office of Worker's Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN.: Clerk of the Board, Post Office Box 37601, Washington, DC 20013-7601. See 20 C.F.R. § 725.478 and § 725.479. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, DC 20210.

[39]Counsel for the Director asserts that *Truitt* is inapplicable because Mr. McCoy does not have complicated pneumoconiosis. Consequently, Holly Beth Company is the appropriate responsible operator.

Attachment No. 1

American Board of Medical Specialties

Certification:

Richard Mullens, MD

Certified by the American Board of Radiology in:

Diagnostic Radiology

American Board of Medical Specialties
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